

RN-BSN education: 21st century barriers and incentives

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Design Qualitative using phenomenological inquiry.

Methods Purposive sample of six RN-BSN students participated in focus group interviews. Data were analysed using Colaizzi's phenomenological method.

Findings Incentives included: (1) being at the right time in life; (2) working with options; (3) Achieving a personal goal; (4) BSN provides a credible professional identity; (5) encouragement from contemporaries; and (6) user-friendly RN-BSN programmes. Barriers included: (1) time; (2) fear; (3) lack of recognition for past educational and life accomplishments; (4) equal treatment of BSN, ASN and diploma RNs; and (5) negative ASN or diploma school experience.

Conclusions RN-BSN educational mobility is imperative as: (a) 70% of practicing RNs (USA) are educated at the ASN or diploma level; (b) nurse academicians and leaders are retiring in large numbers; and (c) research links BSN-educated RNs with improved patient outcomes.

Implications for nursing management RN-BSN educational mobility is imperative to nurse managers and nurse administrators because: (a) research links BSN-educated RNs with improved patient outcomes; (b) nurse leaders and academicians are retiring in large numbers; and (c) approximately 70% of practicing RNs (USA) are educated at the associate degree or diploma level with only 15% moving on to achieve a degree past the associate level. Measures to foster incentives and inhibit barriers (caring curricula and recognition of different educational levels) should be implemented at all levels of nursing practice, management and academia.

Keywords: barriers, education, incentives, nursing, phenomenology, RN-BSN

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Introduction

Despite the fact that the 21st century is well underway and we are purportedly living in an age of social awareness and progress, nursing as a discipline is still struggling with its identity and shortages in clinical staff and faculty. The purpose of this phenomenological study was to explore, document, describe and analyse the perceived barriers and incentives of returning

diploma and ASN RNs in their quest for educational mobility to the level of BSN. Identification of underlying barriers and incentives to nursing educational mobility from associate degree- or diploma-level RN education to the baccalaureate level is significant to nursing in four areas: (a) creation of a credible professional identity; (b) replacement of aging and retiring nurse academicians, managers and leaders; (c) production of independent, critically thinking professionals

Table 1
US academic definitions

Registered Nurse (RN)	Designation for an RN with any level of preparation (Diploma, ASN, or BSN, MSN, PhD)
Diploma	Two year hospital-based degree providing entry-level practice as a RN
Associate of Science in Nursing (ASN)	Two year college degree providing entry-level into practice as a RN
Bachelor of Science in Nursing (BSN)	Four year college degree providing entry-level into practice as a RN
Registered Nurse to Bachelor of Science in Nursing (RN-BSN)	Academic mobility of ASN or diploma RNs to the BSN level of education
Master of Science in Nursing (MSN)	Post-BSN, advanced practice degree in nursing
Doctor of Philosophy (PhD)	Terminal degree in nursing or another discipline i.e. Healthcare Administration

(Ohlen & Segesten 1998, Clark 2002, Joel 2002; Sullivan 2002); and (d) provision of safe, quality patient care (Aiken *et al.* 2003). It is expected that this study will add to the existing information about nursing educational mobility, thus fostering solutions to barriers and encouraging incentives for nurse education advancement to the BSN level (Table 1).

Registered Nurse educational mobility is important to nursing managers and leaders when looking at how patient outcomes are related to educational levels of RNs (Aiken *et al.* 2003). Aiken *et al.* found that nursing's multi-level educational system does not always produce equal patient outcomes. The results of Aiken *et al.*'s research indicate that in hospitals with a 10% increase in the proportion of nurses with BSN degrees, there was a decreased risk of patient death and failure to rescue by 5%. Aiken *et al.*'s results speak clearly to the relevance of how advanced degrees in nursing impact patient care and outcomes. Healthcare administration on all echelons, including business, medical, nursing, financial and legal, would benefit from examining ways to increase the proportion of BSN-level RNs employed at their institutions. Patient outcomes are the culmination of nursing, medical and interdisciplinary care. Everyone in the healthcare system, from the chief executive officer to the nursing vice president to the bedside nurse to the patient, profits when patient outcomes are improved. Of the 2.7 million practicing RNs in the USA, 70.3% are RNs with an associate degree or diploma in nursing (Spratley *et al.* 2001). Educational mobility of these approximate 1.9 million ASN and diploma RNs to the BSN level is crucial to positive patient outcomes, creation of a credible professional identity and to cohesion among nurses.

Background

Associate of Science in Nursing programmes emerged in the early 1960s in the US community college setting as a show of commitment to a balance between nursing and liberal arts studies, thus allowing nursing to break away

from the apprenticeship model of education (Rosentetter & McSweeney 1983; Nelson 2002). Montag (1959), credited with founding associate degree nursing, originally envisioned 2-year ASN education as a means to train a technical nurse to assist the professional nurse prepared at the baccalaureate level. ASN programmes contributed phenomenal growth to the nursing population, producing 60% of newly licensed RNs by the 1990s (Dervarics 2002). This evolution of technical nursing evoked much controversy as Donahue (1995) noted that 'the liaison between nursing and community colleges equated nursing education with vocational training at a time when professional status was being sought for nursing' (p. 380). A crucial historical event took place in 1965 with the American Nurses Association's (ANA) position paper that recommended minimum education for nurses. The ANA (1965) recommended that the 'minimum preparation for beginning professional nursing practice...should be baccalaureate degree education in nursing' (p. 107). The ANA identified three recommended levels of nursing education: baccalaureate education for beginning nursing practice, associate degree education for beginning technical nursing practice and vocational education for assistants in health care. The debate of nursing as a professional *vs.* a technical practice was born. The American Association of Colleges of Nursing, AACN (2000) has also recognized baccalaureate-level nursing as the minimum educational requirement for professional nursing practice.

In a 1996 report by the National Advisory Council on Nurse Education and Practice (NACNEP), national goals related to nursing educational mobility were set by the US government. The NACNEP called for adoption of a policy to achieve a basic RN workforce with two-thirds holding baccalaureate or higher degrees by the year 2010 (Division of Nursing, 1996).

Currently there are 2.7 million RNs in practice in the USA, of which 40.3% have associate degrees, 30% have diplomas in nursing and 29.7% have baccalaureate degrees. Approximately, 16% of RNs initially prepared

in associate degree programmes and 24% of those prepared in diploma programmes have completed additional nursing or nursing related baccalaureate-level degrees (Spratley *et al.* 2001). The current entry-level nursing school graduates are comprised of 60% ASN graduates, 37% BSN graduates and 3% diploma in nursing graduates (AACN 2002).

Methods

A qualitative phenomenological research design was chosen for this study to identify the essence of realities and viewpoints of RN-BSN students in what incites or inhibits RNs from pursuing an advanced degree to the BSN level. Using purposive sampling, participants were solicited from a south-eastern university RN-BSN programme at an external degree campus. Six female RN-BSN students consented to participate in the study. The ages ranged from 23 to 52 years, with a mean of 41 years. All identified their ethnicity as Caucasian. Total years as a licensed RN ranged from 2 to 28 years, with a mean of 17 years. Five of the six participants' highest level of completed education was at the ASN level and one participant's highest level of completed education was at the diploma in nursing level. To maintain confidentiality and enhance the richness of their stories, each participant chose a pseudonym for identification in the study. The study was approved by the institutional review board for human subjects' research prior to data collection.

Data were collected in two focus group interviews. A brief survey was completed by each participant to obtain basic demographic information. Key questions used to guide the focus group interviews included: (a) What incentives are motivating you to pursue a BSN? (b) What do you perceive to be barriers to acquiring a BSN? (c) What barriers did you or are you experiencing in pursuing a BSN? (d) Has anyone, such as your manager or your contemporaries, influenced a decision, either to pursue or to not pursue a BSN? (e) Do you believe a BSN will be a requirement during your lifetime? (f) How has your associate degree or diploma nursing school experience affected your views on pursuing a BSN?

Phenomenology is both a philosophy and a research method. Van Manen (1990) describes phenomenology as a human science which strives to explicate the meaning of human phenomena and to understand the lived structure of meanings. According to Munhall and Boyd (2000), the purpose of phenomenological research is to describe experiences as they are lived with the understanding that the participant is integral with the

environment. Only those who experience phenomena are capable of communicating that experience to the world. In phenomenological research, reality is considered subjective and experience is viewed as unique to the participant (Burns & Grove 1995). Munhall and Boyd assert that being a human is self-interpreting and therefore the only reliable source of information to answer the question of 'What is the meaning of one's lived experience?' is the participant. Understanding the experience requires the participant to interpret the action or experience for the researcher. The researcher must then interpret the explanation given by the participant. In effect, this research method allowed me to borrow the experience of others to provide a description and interpretation of the experiences of returning RN-BSN students' pursuit of educational mobility. Data analysis was performed utilizing Colaizzi's (1978) phenomenological methodological analysis.

Methodological rigor was achieved via Lincoln and Guba's (1985) four trustworthiness criteria for qualitative research which include credibility, transferability, dependability and confirmability. Strict adherence to the four criteria for trustworthiness was maintained throughout the study.

Findings

Table 2 provides an overview of the constitutive patterns and relational themes. The patterns and themes are explored in detail using excerpts from participant interviews, as well as examining context and variations of the participant sample.

Constitutive pattern I: incentives encountered by RN-BSN students

An incentive is something that rouses or encourages a person to some action or effort. During the interviews, participants described their pursuit for educational mobility to the BSN level. They recalled those aspects of their life and life events that roused them to the action of returning to school for a BSN.

Theme I: looking for a point in time: being at the right time and place in life

The concept of appropriate life-timing to pursue a BSN emerged as each described a point in their life as 'the right time and place to go back to school'. A majority of participants recounted how life events such as child-bearing and childrearing did not provide an opportune time to return to school. They explained how, at a very specific point in their life, when other life commitments

Table 2
Constitutive patterns and themes

<i>Pattern</i>	<i>Themes</i>
Incentives encountered by RN-BSN students	Looking for a point in time: being at the right time and place in life Looking forward: continuing to work with options Looking inward: advancing education is achieving a personal goal Others looking at me: believing a BSN provides a credible professional identity Looking for support: being encouraged by contemporaries to return to school Looking for a place: finding accepting and user-friendly RN-BSN programmes
Barriers encountered by RN-BSN students	Not enough: time Not enough confidence: fear Not enough recognition: past educational and life accomplishments Not enough differentiation: equal treatment of BSN, ASN and diploma RNs Not enough basic academic support: negative ASN or diploma school experience

had been met or lessened in degree of attention, they were able to then clearly make the decision to go back to school. Alexis described this epiphany, 'I think you really have to have that mind set that you are ready to do it [go back for BSN]...you know when that time comes and it just clicks, like I've got to do that'. The participants' stories were rich with descriptions of how they 'just knew' it was the 'right time' to go back to school for a BSN. As their lives afforded appropriate time away from family, they were then able to pursue educational endeavours.

Theme II: looking forward: continuing to work with options

Participants described the experience of evaluating their professional lives. Five of the participants recalled how they came to realize that if they were to continue their life's work in the nursing field it would be enhanced with the options afforded by a BSN-level education. All participants described how the physical nature of their current 'staff nurse' jobs, along with advancing age, made them re-examine their career prospects as nurses. The participants conveyed a desire for freedom from the traditional 24 h-a-day, 7 days-a-week, 365 days-a-year nursing work mentality. Billie related this inclination to work with options, 'I want a job where I don't have to do that [12 hour shifts, holidays, weekends] and I think you have to have your BSN to get those jobs'. The belief that a BSN is required to work in a nursing job other than day-to-day caregiver was described by Linda, 'Any upper-level management [position] will definitely require a BSN to progress. I don't think the caregivers necessarily will be demanded to have a BSN but it will be a very much needed credential for anything above that'. The theme of looking forward and continuing to work with options presented an incentive for RN educational mobility grounded in participant introspection and evaluation of potential life careers.

Theme III: looking inward: advancing education is achieving a personal goal

The prospect of realizing personal ambition in advancing to a BSN-level degree permeated the participants' comments. The participants described an inner yearning to learn and to attain a higher, more critical level of thinking. An overwhelming majority spoke of the goal of obtaining a BSN as one that was born as they graduated from their ASN or diploma programmes. Alexis stated, 'I always knew I wanted to go back [to obtain a BSN]'. Many of the participants actually started back to school for their BSN within 2 years of ASN or diploma graduation, but had to put BSN completion on hold in lieu of family, work and personal commitments.

Theme IV: others looking at me: believing a BSN provides a credible professional identity

There was an overwhelming and cohesive group response in the belief that obtaining a BSN would provide a credible professional identity. The participants described credible professional identity as a distinct view of BSN RNs held by others and themselves. The participants defined credible professional identity as the inherent respect, based on educational level, conferred to BSN or higher level educated RNs. The participants also described the belief that a BSN will be required for professional and upper management-level positions, those other than clinical staff nurse positions.

All agreed that as ASN or diploma prepared RNs, they felt less credible, professionally, than BSN RNs. Katie offered an example of how her self-view of professional credibility was pivotally altered:

'The first time I really realized it [that a BSN provides credibility] was when I was asked to do a workshop in Atlanta and there were 250 or 300 nurses there. I was one of the presenters and they

asked me “What letters do you want out by your name?” I just said “RN.” They said “What other degrees do you have?” and I said “RN is fine.” I realized that they respected me and knew I could do a good job but all of a sudden I just wasn’t as credible without those letters (BSN)’.

Other participants echoed Katie’s belief that credibility comes with advanced education. Lynn described instances in which she felt the credibility of ASN nurses was questioned by others aware of the difference between ASN and BSN levels of education. Lynn illustrated this point, ‘I have seen people ask nurses “Are you associate?” or “Are you BSN?” Just the way they ask it you can tell it just seems to make a difference [in credibility]’. Katie provided an example of how the basic desire for credibility had spurred her on to obtaining a BSN, ‘Something came to me when I was in a workshop and we were talking about goals and what we wanted from our careers. I realized that maybe what I want from it is just some credibility. To have a BSN gives you more credibility than not to have a (BSN)’.

Without exception, the participants voiced the belief that a BSN will be required for professional level and upper management nursing positions at some point in their lifetime. Each participant expressed the belief that if she wanted to advance professionally as a nurse, she would need to complete a BSN. One participant, Olivia, described how educational mobility is required for maintenance of her current nursing job. Olivia works at the management level as a clinical resource nurse and ‘to come back to school and be working for my Master’s degree was one of the requirements of getting the job’. The participants’ certainty over nursing’s professional evolution to the BSN level for professional and management level jobs was a driving incentive for educational mobility.

Theme V: looking for support: being encouraged by contemporaries to return to school

The participants cited encouragement from colleagues who had completed an RN-BSN programme as an incentive to return for a BSN. The support and positive stories from friends who had lived the RN-BSN school experience was, for some, the turning point in making the decision to return to school. Lynn, Katie and Billie all reported that it was the positive influence of colleagues that fostered their decision to return for a BSN. Lynn recounted the following experience, ‘After talking with friends who had worked on their BSN, they told me it was nothing like the associate programme. My

friends eased my mind and helped me make that final big step [to go back for my BSN]’.

Theme VI: looking for a place: finding accepting and user-friendly RN-BSN programmes

All participants described in some fashion or form the accepting and user-friendly characteristics of RN-BSN programmes as an incentive to return to school. The most frequently cited favourable RN-BSN programme characteristic was the acceptance of ASN or diploma coursework in transfer of credits. Much discussion revolved around this topic with Linda, Lynn, Olivia and Katie all referring to the importance placed on an RN-BSN programme willing to accept previous coursework.

Other RN-BSN programme characteristics with a positive influence on participants’ decisions to return to school included: (a) accessible geographical location; (b) waived out-of-state tuition; (c) requirement of less clinical hours than traditional BSN or other RN-BSN programmes; and (d) face-to-face programme *vs.* online programmes. Each participant described a process of searching for the ‘right school’ to fit personal, professional and educational needs.

Constitutive Pattern II: barriers encountered by RN-BSN students

The participants recounted those aspects of their personal and professional lives that prevented progress in their quest for returning to school for a BSN. Each theme will be described in detail and supported with excerpts from participant interviews.

Theme I: not enough: time

Issues related to time were cited unanimously by participants as a primary barrier in the quest to return to school for a BSN. Discussion related to time as a barrier centred on the personal commitments of the participants. Five of the six participants offered commitment to childbearing and childrearing as a primary barrier in educational mobility. Lynn recalled, ‘I was raising my children and it just wasn’t convenient at that time to go back to school for a BSN’. Olivia described how commitment to family surpassed educational mobility as a priority, ‘time constraints with a teenager and younger child placed a lot of impact on my time, making it very difficult’ to pursue a BSN. Alexis, a RN for 10 years, recounted the following experience related to time as a barrier:

‘This is my second time to work on my BSN. The first time my first child was 9 months old. I took a

couple of semesters but it was just too much at that time. I was taking two or three classes and working full time. I was a new wife and a new mom so I took a break from school and didn't come back until now, when my daughter and son are older'.

Conflicting RN-BSN programme and work schedules were also cited by a majority of the participants as a barrier in returning to school. Time, specifically the lack of, provided a common thread in identification of a central barrier to the participants' pursuit of a BSN.

Theme II: not enough confidence: fear

Fear as a barrier took multiple forms for the participants. These forms of fear included: (a) fear of returning to an academic setting; (b) fear related to negative ASN or diploma school experience; and (c) fear of technology. With the average number of years from ASN or diploma graduation being 17, a majority of these participants described fears of being unable to meet the standards or to retain classroom information.

Fear related to a negative ASN or diploma school experience recurred throughout the participants' stories. The participants described a fear that RN-BSN programmes would be 'as miserable' as their ASN or diploma school experience. Lynn, Katie and Alexis all recalled how their 'negative associate' nursing school experience made them fearful of what was to come in a BSN programme. The three RNs described how this very real fear contributed to decisions to delay returning to school, 'it took years to get over the associate school experience' and 'be able to look forward to a BSN'.

Fear of technology permeated the stories. A factor of this fear relates, again, to the average of 17 years this group was removed from their primary nursing academic experience and their perceived gap in technological knowledge. The participants described fears of being unable to 'keep up with technology' and of working with 'new computer programmes'. Participants expressed concern over using computers and related technology to prepare presentations and papers, something not required of them in their ASN or diploma schools.

Theme III: not enough recognition: past educational and life accomplishments

Participants related stories and experiences in which barriers took the form of RN-BSN programmes' complete lack of recognition for past educational and life accomplishments. The participants described a journey to return to school that was met with nurse academicians who disregarded the wealth of nursing and life

experience embodied in these women. The participants recounted how, upon meeting with nursing advisors at various RN-BSN programmes, they were greeted with treatment commensurate of a prospective BSN student with no previous nursing or life experience. Katie communicated this frustrating process with the following story:

'I spent 3 years at a university in Georgia in special education and then changed midstream eventually finishing my ASN. I went to a university in Tennessee and they said, "We'll be glad to give you a degree but you'll have to go 4 years for it." I said "forget that, I've already got five, I don't need 4 more to get a BSN, when I had already been a RN for 17 years"'.

In their research of various RN-BSN programmes, participants recounted how consistently their attempts at transferring ASN or diploma credits were met with denial. Lynn described the difficulty she experienced in attempting to gain entrance into a school that was geographically convenient but ultimately unaccepting of her coursework. Lynn's story detailed how she had applied, been accepted, and attended a new student orientation at a state-run, upper division university only to find that this university was going to require she 're-take up to 24 core courses' to graduate with a BSN.

The participants also described frustration at the lack of recognition they expected should come with years of nursing work and life experience. Linda and Lynn offered similar stories regarding their quest to find accepting RN-BSN programmes. Both women stated that none of the RN-BSN programmes they looked at would give any credit for each of their 28 years of work experience as RNs. Linda and Lynn, along with a majority of the other participants, agreed that if RN-BSN programmes would have in some way acknowledged, recognized or given credit for years of RN work experience they would have been more likely to return for their BSN much sooner than they did.

Theme IV: not enough differentiation: equal treatment of BSN, ASN and diploma RNs

A barrier central to the stories of a majority of participants focused on the belief that they had never seen any reason to pursue nursing educational mobility to the BSN level. The participants described equal treatment of BSN, ASN and diploma RNs with regard to pay differentials, job classifications and professional status. This belief was fostered by healthcare institutions that provided little, if any, pay differential for BSN-educated

RNs, commensurate job opportunities for both ASN and BSN RNs, and insignificant, if any, recognition of those RNs who completed BSN degrees. Katie's sentiment was reflective of the group, 'There was never a need for it [BSN]...I was making as much money as BSN RNs and had the same positions without the degree'. In reference to pay differentials, participants' stories exhibited strong feelings on the subject as illustrated by Linda's narrative, 'Even if nurses had a desire to go back, it wasn't worth the time they invested. It wasn't worth their [BSN RNs] time to make 30 cents more an hour'. Linda's experience was affirmed by Lynn's story:

'The floor I work on, you don't make any more money having your BSN versus your associate's degree. I think that may keep some people from going back for their BSN. You think "if you're not going to make any more money why go through that [additional school]?"'

The participants' strong feelings and stories clearly identified equal treatment of RNs with different education levels as a barrier for returning for a BSN. The desire to attain educational mobility was quashed by healthcare institutions that failed to recognize any difference between the three levels of education. The participants interpreted this equal treatment of ASN, diploma, and BSN RNs as a warning to not 'waste' time and effort in returning for a BSN.

Theme V: not enough basic academic support: negative ASN or diploma school experience

A majority of participants described negative primary nursing school experiences as having a lasting, almost traumatic effect on their vision to attain a BSN. Various participants depicted stories from their ASN or diploma in nursing programmes that created unsettling views of nursing academia. Lynn illustrated her experience with this story:

'Getting my associate's degree was the hardest thing I have ever done. When I first graduated I said, "I never want to go back to school." It was just awful. It took a couple of years to get over that. It was negative'.

Other participants recounted how their experience in ASN or diploma in nursing school made them believe, to a certain extent, that a BSN programme would be 'just the same negative experience'. Alexis relayed her feelings with these comments:

'It was a negative experience. I had a few instructors that were really great, but for the most

part it just seemed like they were out to trick you and it was just difficult. I kept telling my husband that the BSN program just had to be different from the associate program'.

It is clear, from almost unanimous participant comments, that negative experiences at the ASN and diploma level of nursing education provided a barrier in returning to school for a BSN.

Discussion

The findings provide insight into how 21st century RNs approach educational mobility to the BSN level. Significant differences were noted between the findings of this research and the previous research on incentives and barriers in RN-BSN educational mobility. There is a perceptible shift from tangible barriers such as cost and class scheduling (NLN 1987, Lethbridge 1989, Krawczyk 1997) to more intangible barriers experienced by the participants in this study. Intangible barriers reported by the participants include time, fear and prior negative ASN or diploma school experience. This shift implies that RN-BSN programmes are becoming more user-friendly for RNs seeking educational mobility but that today's RN-BSN student is faced with different barriers. The barriers of lack of time and fear are issues not easily remedied by academia or healthcare employers. Implications of this research for nursing practice, administration, leadership and education are presented with practical potential solutions to reduce barriers and to develop incentives for nursing educational mobility.

Implications for nursing practice

An important area of nursing practice to consider is how patient outcomes relate to RN educational levels. Aiken *et al.* (2003) found that nursing's multi-level educational system does not always produce equal patient outcomes. The results of Aiken *et al.*'s research indicate that in hospitals with a 10% increase in the proportion of nurses with BSN degrees, there was a decreased risk of patient death and failure to rescue by 5%. Aiken *et al.*'s results speak clearly to the relevance of how advanced degrees in nursing impact patient care and outcomes. Educational mobility should be a priority for healthcare institutions interested in improving patient outcomes. Healthcare institutions could provide significant pay differentials for diploma, ASN and BSN RNs and make a BSN a requirement for certain

positions such as charge nurse, team leader or manager. If institutions began a process of differentiation between educational levels of RNs, an increase in RN-BSN students would occur naturally. This assertion is supported by the participants who saw no reason to advance their education to a BSN when healthcare institutions provided: (a) little, if any, pay differentials for BSN-educated RNs; (b) commensurate job opportunities for diploma, ASN and BSN RNs; and (c) insignificant, if any, recognition of those RNs who completed BSN degrees. Nursing practice, and thus patient outcomes, could be positively influenced by increasing the proportion of BSN-educated RNs.

Implications for nursing administration and leadership

The results of this study can impact nursing administration practices by providing data to support that RNs: (a) want to be recognized and rewarded for educational accomplishments; (b) want to be able to work with the options afforded BSN-level nurses; (c) are more likely to pursue educational mobility to the BSN level if there are significant pay differentials; (d) crave the credible professional identity they believe accompanies a BSN; (e) want nursing to be not just a job but a career; and (f) seek mentors who play a significant role in motivation to pursue educational mobility. Nursing administrators would benefit from actively listening to their nursing employees' desires and goals. Administrators might be surprised to discover how strongly diploma and ASN RNs crave the professional credible identity associated with a BSN. According to the participants' comments, today's nurse executives would also be surprised to find that RNs want managers and administrators to recognize a difference between educational levels of diploma, ASN and BSN RNs. Active RN-BSN mentorship, recognition, pay differential and job opportunities commensurate with a BSN-level education are all ways in which nursing administration could advocate for educational mobility of diploma and ASN RNs.

Implications for nursing education

Based on the findings from this study, recommendations for nurse educators can be made. Nurse educators and nursing academia can: (a) recognize and apply credit for past educational and life experiences of ASN and diploma RNs; (b) take an active role in articulation agreements, (c) embrace the RN-BSN student with support and encouragement; (d) implement caring curricula and RN-BSN student mentor

programmes; and (e) cultivate a positive ASN or diploma school experience. For this study's participants, the thought of going back to school for a BSN was laced with fear of technology, fear of failure and fear related to negative ASN or diploma nursing school experiences. Nurse educators are in a prime position to curb these fears. ASN and diploma-level nurse educators can nurture more positive experiences and foster a culture of forward-thinking and educational mobility as the norm.

Nurse educators in BSN programmes are in a prime, frontline position to graciously welcome potential ASN and diploma RN students into the world of academia. Academia has taken initial steps to ease the transition of ASN and diploma RNs into a baccalaureate setting by embracing articulation agreements, scheduling classes to accommodate working students, and, most importantly, by accepting the ASN and diploma RNs work and life experience (Thomas Jefferson University, 2004).

Conclusions

The research findings reflect the struggles and inspirations encountered by RN-BSN students in their quest for higher education. The participants were driven to educational mobility by the desire to attain professional credibility and to work with the options afforded those with an advanced nursing degree. The participants in this group were motivated by recognition that, as an ASN or diploma RN, they were often perceived negatively or treated less professionally because they lacked a BSN. This mature group possessed a thoughtful perception and awareness of the professional credibility that accompanies advanced degrees in nursing. The participants also recognized the benefit a BSN would provide in working with options. The group indicated a keen awareness of their physical limitations in continuing to work a lifetime as a staff nurse. The participants had reached a point in their lives in which timing, experience and encouragement from contemporaries, and discovery of receptive RN-BSN programmes culminated in fruition of a personal and professional goal to attain a BSN.

Future research is warranted to explore deeper spheres of nursing educational mobility. Recommended future research related to barriers and incentives of ASN or diploma RNs returning for a BSN include: (a) quantitative studies exploring demographically similar and different RN-BSN populations; (b) research investigating national RN-BSN curricular or programme characteristics; and (c) surveys ascertaining public opinion on educational levels of RNs.

Lack of uniform educational preparation remains a controversial subject in nursing's quest to achieve a credible professional identity (Joel 2002). The results of this study have the potential to impact nursing practice, nursing education, nursing and healthcare leadership practices; and management customs. Patient outcomes, credibility for the nursing profession, commensurate compensation and curricular design could all be positively influenced or improved with implementation of measures to reduce barriers and foster incentives in ASN or diploma RN educational mobility to the BSN level. The results have the potential to affect practical and relevant change if educational barriers are removed and incentives are cultivated.

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